EXHIBIT B-3

Blumberg No. 5116

MEDICATION ADMINISTRATION RECORD

NaphCare

MEDICATIONS	HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30
ASA/APAP x30d 9/11 - 10/11/02	K O P — effective 9/17/02
Neosporin eye oint TID x10 10/4 - 10/14/02	Kep — 4 — 1

MEDICATIONS	HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 10-1-02 THROUGH 10-31-02

Physician Brunner | Telephone Number | Inmate No

Alt. Physician | Alt. Telephone

Allergies NKA | Rehabilitative Potential

Diagnosis

Medicaid Number | Medicare Number | Complete Entries Checked By: AS Smith Title: LPN Date: 10/1/02

PATIENT Annette Bowen | PATIENT CODE 2179055 | ROOM NO | BED | FACILITY C(

MEDICATION ADMINISTRATION RECORD

NaphCare

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
TAO to posterior neck tid x14 day KOP 5/1/02 5/13/02	6A 12 6P	Given 5/4/02 Aschekja																													

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 5-1-02 THROUGH 5-31-02

Physician

Alt. Physician B. Helm CRNP

Telephone Number

Alt. Telephone

Inmate No. 217905

Allergies NKA

Rehabilitative Potential

Diagnosis

Medicaid Number

Medicare Number

Complete Entries Checked By: J. Jones LPN Title: LPN Date: 5/1/02

PATIENT Averette Zavius

PATIENT CODE 217905

ROOM NO.

BED

FACILITY CODE Staton

MEDICATION ADMINISTRATION RECORD

NaphCare

MEDICATIONS	HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30
Tegel shampoo to wash scalp 3xwk x30d sup 3/22/02-4/22/02	KO given 3/26/02
AFC/powder to feet TID x30days 3/22-4/22/02	KO given 1 powder 3/26/02

MEDICATIONS	HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 4/1/02 THROUGH 4/30/02

Physician	Telephone Number	Inmate No. 217905
Alt. Physician	Alt. Telephone	
Allergies NKA	Rehabilitative Potential	
Diagnosis		
Medicaid Number	Medicare Number	Complete Entries Checked By: [illegible] Title: Date: 3/25/
PATIENT Annette Zach Zavorus	PATIENT CODE	ROOM NO / BED / FACILITY Ste

PRS: NAPI

EDICATION OMINISTRATION RECORD

NaphCare

MEDICATIONS	HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
Lget Shampoo to Use in Scalp 3x/wk x30d 3/22 - 4/22/02 Days	IC JP
Antifugal cr/pwd to feet tid x30d 3/22 - 4/22/02 Days	IC JP

MEDICATIONS	HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 3.1.02 THROUGH 3.31.02

Physician Dewyer

Alt. Physician

Allergies NKDA

Diagnosis

Telephone Number

Alt. Telephone

Rehabilitative Potential

Inmate No 2179

Medicare Number

Complete Entries Checked By:

Title: LPN

Date:

PATIENT CODE

ROOM NO

BED

Davis

MEDICATION ADMINISTRATION RECORD

NaphCare

MEDICATIONS	HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30
T-gel Shampoo to scalp 4x/wk 10/25 – 11/[illegible]/01 daily	
Keflex 500mg – p.o. TID x10 days 10/29/01 — 11/8/01	
MEDICATIONS	HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 11.01.01 THROUGH 11.30.01

Physician Zaylor

Telephone Number

Inmate No 217905

Alt. Physician

Alt. Telephone

Allergies NKA.

Rehabilitative Potential

Diagnosis

Medicaid Number

Medicare Number

Complete Entries Checked By: [signature] Title: NP Date: 9/25/01

PATIENT Averette, Zavious

PATIENT CODE 217905

ROOM NO

BED

FACILITY C

MEDICATION ADMINISTRATION RECORD

MedPhCare

MEDICATIONS	HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28
750333 THERAPEUTIC SHAMPOO 240ML 09/11/01 K APPLY TO AFFECTED AREA TWICE A WEEK FOR 30 DAYS KEEP ON PERSON Stop: 10/11/01	O P
T-gell Shampoo to scalp 4x/wk 10/25/01 – 11/25/01 daily	O P
Keflex 500mg i p.o. TID x 10 days 10/29/01 – 11/8/01	6A 2W 6P

MEDICATIONS	HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FROM 10/01/01 THROUGH 10/31/01

Physician Taylor | Telephone No | Inmate No 2179

Alt Physician | Alt Telephone

Allergies NKA | Referral/Hold for Potential

Complete Entries Checked

By: Title: Date:

PART I CODE

MEDICATION ADMINISTRATION RECORD

NaphCare

MEDICATIONS	HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30
T-gel Shampoo 2x per week x 30d 15 15 9/12/01 – 10/12/01	K O P — qam 9/15/01 Abechlyn
Synalar oint to back of scalp TID x 14d 9/12/01 – 9/26/01	K O P — qam 9/12/01
Neosporin Opthalmic oint To eye TID x 14d 9/11/01 – 9/25/01	K O P — qam 9/11/01

MEDICATIONS	HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 9/1/01 THROUGH 9/30/01

Physician Taylor

Alt. Physician

Allergies NKA

Dia

Telephone Number

Alt. Telephone

Inmate No. 217905

Rehabilitative Potential

Medicaid Number

Medicare Number

Complete Entries Checked By: Brick Gp Title: Date: 9/11/01

PATIENT Averette Tavious

PATIENT CODE | ROOM NO | BED | FACILITY STATE

NaphCare

Health Services Request Form

Print Name Zavius A Averette Date of Request 8-31

ID No. 217905 Date of Birth N/A Housing Location East Do

Nature of problem or request I really need something for my feet and a rash.

Thank you for your time.

Zavius A Averette

Sign here for consent to be treated by health staff for the condition described above.

Place this slip in Medical Box or designated area
DO NOT WRITE BELOW THIS LINE

Health Care Documentation

Subjective

Objective BP_____ P_____ R_____ T_____

Assessment

Plan

NO SHOW
8/22/01
P. Bowen, LPN

Refer to ○ PA/Physician ○ Mental Health ○ Dental

Signature_____ Title_____ Date_____

MEDICATION ADMINISTRATION RECORD

NaphCare

MEDICATIONS	HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30
[redacted] ciprofloxacin 500mg P.O. 48hrs c food x 5 days 12/21/2001 - 12/26/2001	6A 12N 6P

MEDICATIONS	HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR Dec 2001 THROUGH Dec 2001

Physician	Telephone Number	Inmate No
Alt. Physician	Alt. Telephone	
Allergies	Rehabilitative Potential	
Diagnosis		
Medicaid Number	Medicare Number	Complete Entries Checked By: [redacted] Title: Date: 12/2001
PATIENT Averette, Zavius	PATIENT CODE 217905	ROOM NO BED Stator FACILITY CODE

PFS NAPHC

11/22/2004 MON 12:27 FAX 334 ... 7 1538 Staton Health Unit
003/028

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

PHS

DEMOGRAPHICS

Site Name & Number: Staton 843 – S cc

Patient Name: (Last, First,) Averette, Zavius

Date: (mm/dd/yy) 11/21/04

Site Phone #: (334) 567 - 1548

Alias: (Last, First,)

Date of Birth: (mm/dd/yy) [redacted]

Site Fax #: (334) 567 - 1538

Inmate #: 217905

PHS Custody Date: (mm/dd/yy) 06/27/01

Will there be a charge? ☒ Yes ☐ No

Sex: ☒ Male ☐ Female

SS Number: [redacted]

Potential Release Date: (mm/dd/yy) 03/16/16

Responsible party: ☒ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare and Medicaid):

CLINICAL DATA

Requesting Provider: ☒ Physician ☐ NP, PA ☐ Dentist

WINFRED D. WILLIAMS

Facility Medical Director Signature and Date:

Dwight D. Sellers

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☒ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)

☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☒ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) ___/___/___

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy

Number of Visits/Treatments: ___ ☐ Other: ___

Specialist referred to: Dr. Bradford

Type of Consultation, Treatment, Procedure or Surgery:

Onsite eye exam

History of illness/injury/symptoms with Date of Onset:

N/A 20/40 (R) 5 glasses
20/30 (L)

Results of a complaint directed physical examination:

Previous treatment and response (including medications):

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☒ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information.

Date resubmitted: ___/___/___

Regional Medical Director Signature, printed name and date required:

11/22/04 (mm/dd/yy)

Do not write below this line. For Case Managers and Corporate Data Entry ONLY:

Cert Type:	Med Class:	UR Auth #:
OT/OV	99201	1444160

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

PHS

DEMOGRAPHICS

Site Name & Number: Staton 843 - S CC	Patient Name: (Last, First,) Averette, Zavius	Date: (mm/dd/yy) 11/21/04
Site Phone # (334) 567 - 1548	Alias: (Last, First,)	Date of Birth: (mm/dd/yy) [redacted]
Site Fax # (334) 567 - 1538	Inmate # 217905	PHS Custody Date: (mm/dd/yy) 06/27/01
Will there be a charge? [X] Yes [ ] No / Sex [X] Male [ ] Female	SS Number [redacted]	Potential Release Date: (mm/dd/yy) 03/16

Responsible party: [X] PHS [ ] Auto Ins. [ ] Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) [ ] Other, be specific (Excludes Medicare and Medicaid):

CLINICAL DATA

Requesting Provider: [X] Physician [ ] NP, PA [ ] Dental

WINFRED D. WILLIAMS

Facility Medical Director Signaure and Date:

[ ] Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

[X] Office Visit (OV) [ ] X-ray (XR) [ ] Scheduled Admission (SA)
[ ] Outpatient Surgery (OS) [ ] Dialysis (DA)

[X] Routine [ ] Urgent

Estimated Date of Service (mm/dd/yy) __/__/__

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: [ ] Radiation therapy [ ] Chemotherapy

Number of Visits/Treatments: ____ [ ] Other: ____

Specialist referred to: Dr. Bradford

Type of Consultation, Treatment, Procedure or Surgery:
Onsite eye exam

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

[ ] Pertinent Documents have been attached and faxed.

History of illness/injury/sypmtoms with Date of Onset:
N/A 20/40 (R) 5 glasses
20/30 (L)

Results of a complaint directed physical examination:

Previous treatment and response (including medications):

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION: [ ] Offsite Service Recommended and Authorized

[ ] Alternative Treatment Plan (explain here):

[ ] More Information Requested: (See Attached)

[ ] Resubmitted with requested information. Date resubmitted: __/__/__

FAXED 11/22/04

Regional Medical Director Signature, printed name and date required:

__/__/__ (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:	Med Class:	UR Auth #:

PRISON HEALTH SERVICES: AUTHORIZATION LETTER

Patient Name:	Averette, Zavius	**Inmate Number:**	217905AV
Service Authorized:	Office Visits: Outpatient Optometry Referral	**Effective Dates:**	11/29/2004
Effective:	Visits authorized for 60 days from effective date.	**Visits Authorized:**	1
Responsible Facility:	Staton Correctional Facility	**Contact Name:**	Michelle Pope
Authorization Number:	14441160	**Telephone Number:**	(334)395-5973 Ext 14

Note to Provider of Services:

- **Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.**
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility.
- HIPAA: Please be advised Prison Health Services, Inc. ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of Individually Identifiable Health Information Standard ("Privacy Rule"). Because PHS does not engage in electronic transactions under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule does not apply to PHS.
- Payment will not be processed until we receive a clinical summary.

For Payment Please Submit Claims To:

Prison Health Services
P.O. Box 967
Brentwood, TN 37024-0967

The consulting physician should complete this section.
The completed form will be sealed in the attached envelope and returned with an officer to the correctional facility.

Clinical Summary or Attached Report

***** For security and safety, please do not inform patient of possible follow-up appointments. *****

Signature of Consulting Physician: _____ Date _____ Time

Reviewed and Signed By
Medical Director: _____ Date _____ Time

EYE EXAMINATION SHEET

TO: (Service Physician)	FROM: (Requesting Ward, Med. Fac. Phys.)	Date of Request:
DR. BRADFORD	STATON	12/3/04

Reason For Request: (Complaints and Finding)

Past History

Old Rx

Signature

Type of Consult ☐Emergency ☐Routine

CONSULTATION REPORT

Subjective: OD 20/40 OS 20/30 s̄ glasses

OPHTH: 106 c 6/ [illegible]

New Rx: OD OS

Seg. Ht.

Ext:
Date Dispensed & Initials:

Seg. Type:

PLANO -075 x 100
-025 -100 x 085 / F7W

75

IDP & Time:

52/18/145

Frame:
Size:
Color:

[illegible] 12/3/4

OPTOMETRIST'S SIGNATURE

Patients Last Name	First	Middle	Age	R/S	I D No.
AVERETTE	ZARIUS		25		217905

F-65 Rev. (1-95)

(Staton)

NaphCare

OFF-SITE HEALTHCARE/EMERGENCY ROOM REFERRAL

Inmate name: Averette, Jamus ID#: 217905 SS#:

DOB: [redacted] REFERRED BY: Dr. Taylor DATE: 12/12 FACILITY/COST CENTER: 5021

INMATE COMPLAINT/SIGNIFICANT MEDICAL DATA (Chronic conditions, allergies, current medications):

- large chalazion (Upper lid 11a recommend excision per Dr. Paulk) 11a

SERVICES REQUESTED/PROVIDER: ○ AMBULANCE

schedule for I+D of lesion
Dr. Paulk 1680 Winton Blount
on 12/21 @ 3:15pm Blount

MEDICAL DIRECTOR APPROVAL: BT Daylor MD DATE/TIME: 12/12/01

INSTRUCTIONS TO OFF-SITE PROVIDER:

1. Authorization is provided ONLY for requested procedure and treatment of life-threatening conditions. Prior approval of NAPHCARE Medical Director is required for additional procedures or hospitalization.
2. Because of security concerns, inmates must NOT be informed of follow-up appointments or possible hospitalization.
3. Complete bottom portion of Off-Site Healthcare Referral Form for preliminary documentation of services provided. Return this form in a sealed envelope with the Correctional Officer when inmate is returned to the facility.

NAPHCARE CONTACT: BLOUNT PHONE: 567-1548 (334)

OFF-SITE HEALTHCARE REPORT
Significant Findings/Tests Completed/Diagnosis:

Treatment Provided: Chalazion Removal (I&D)

Orders/Recommendations: IB Rx PRN - RTO PRN

PHYSICIAN: D. Guinn Paulk DATE/TIME: 12/21/01

NAPHCARE MEDICAL DIRECTOR REVIEW OF CONSULTANT ORDERS/RECOMMENDATIONS

Approved: ___ Revised (see medical record) ___ Signature: BT Daylor MD Date/Time: 12/21/01 (1915)

Bill to:
NaphCare
850 22nd St. N.
Birmingham, AL 35203
Phone 1-800-534-2420

Auth# @11217 STOPS.

Naphcare7176 Rev. 3/01

(Staton)

NaphCare

OFF-SITE HEALTHCARE/EMERGENCY ROOM REFERRAL

Inmate name: Averette, Zavius ID# 217905 SS#

DOB [redacted] REFERRED BY: Dr. Taylor DATE: 12/12 FACILITY/COST CENTER: 5021

INMATE COMPLAINT/SIGNIFICANT MEDICAL DATA (Chronic conditions, allergies, current medications):

— large chalazion (L) upper lid & recommend excision (per Dr. Paulk)

SERVICES REQUESTED/PROVIDER: ○ AMBULANCE

Schedule for I&D (L) lesion Dr. Paulk 6880 Winton Blount on 12/21 @ 315pm Blount

MEDICAL DIRECTOR APPROVAL: Dr. Taylor MD DATE/TIME: 12/12/01

INSTRUCTIONS TO OFF-SITE PROVIDER:

1. Authorization is provided ONLY for requested procedure and treatment of life-threatening conditions. Prior approval of NAPHCARE Medical Director is required for additional procedures or hospitalization.
2. Because of security concerns, inmates must NOT be informed of follow-up appointments or possible hospitalization.
3. Complete bottom portion of Off-Site Healthcare Referral Form for preliminary documentation of services provided. Return this form in a sealed envelope with the Correctional Officer when inmate is returned to the facility.

NAPHCARE CONTACT: ______ PHONE: ______

OFF-SITE HEALTHCARE REPORT

Significant Findings/Tests Completed/Diagnosis:

Treatment Provided:

Orders/Recommendations:

PHYSICIAN: ______ DATE/TIME: ______

NAPHCARE MEDICAL DIRECTOR REVIEW OF CONSULTANT ORDERS/RECOMMENDATIONS

Approved: ____ Revised (see medical record) ____ Signature: ______ Date/Time ______

Bill to:
NaphCare
950 22nd St. N.
Birmingham, AL 35203
Phone 1-800-834-2420

Auth# 011217STOP0.

Naphcare7176 Rev. 3/01

(Staton)

NaphCare

OFF-SITE HEALTHCARE/EMERGENCY ROOM REFERRAL

Inmate name: Averette, Zavius ID# 217905 SS#

DOB [redacted] REFERRED BY: for Dr. Taylor DATE: 12/12 FACILITY/COST CENTER: 5021

INMATE COMPLAINT/SIGNIFICANT MEDICAL DATA (Chronic conditions, allergies, current medications):

- Large Chalazion (L) upper lid "

recommend excision (per Dr. Paulk) "

SERVICES REQUESTED/PROVIDER: ○ AMBULANCE

Schedule for I&D of lesion Dr. Paulk

FAXED 12/14/01

MEDICAL DIRECTOR APPROVAL: B. Taylor MD DATE/TIME: 12/12/01

INSTRUCTIONS TO OFF-SITE PROVIDER:

1. Authorization is provided ONLY for requested procedure and treatment of life-threatening conditions. Prior approval of NAPHCARE Medical Director is required for additional procedures or hospitalization.
2. Because of security concerns, inmates must NOT be informed of follow-up appointments or possible hospitalization.
3. Complete bottom portion of Off-Site Healthcare Referral Form for preliminary documentation of services provided. Return this form in a sealed envelope with the Correctional Officer when inmate is returned to the facility.

NAPHCARE CONTACT: ______ PHONE: ______

OFF-SITE HEALTHCARE REPORT

Significant Findings/Tests Completed/Diagnosis:

Treatment Provided:

Orders/Recommendations:

PHYSICIAN: ______ DATE/TIME: ______

NAPHCARE MEDICAL DIRECTOR REVIEW OF CONSULTANT ORDERS/RECOMMENDATIONS

Approved: ____ Revised (see medical record) ____ Signature: ______ Date/Time ______

Bill to:
NaphCare
950 22nd St. N.
Birmingham, AL 35203
Phone 1-800-834-2420

Auth# ______

FILE No.423 11/13 01 12:01 TX STATION 400 PAGE 03/07

(Staton)

NaphCare

OFF-SITE HEALTHCARE/EMERGENCY ROOM REFERRAL

Inmate Name: Everette, Zavius ID# 277905 SS#

DOB [redacted] REFERRED BY: Leo D. Bradford (Taylor) DATE: 11/12 FACILITY/COST CENTER: 5021

INMATE COMPLAINT/SIGNIFICANT MEDICAL DATA (Chronic conditions, allergies, current medications):

Large Chalazion ⓛ upper lid.

SERVICES REQUESTED/PROVIDER: ○ AMBULANCE

Opthalmology - Dr. Faulk.
10200 Highway 231 North
on 12/11 @ 2:40 PM

MEDICAL DIRECTOR APPROVAL: Leo D. Bradford (Taylor) DATE/TIME: 11/12/01

INSTRUCTIONS TO OFF-SITE PROVIDER:

1. Authorization is provided ONLY for requested procedure and treatment of life-threatening conditions. Prior approval of NAPHCARE Medical Director is required for additional procedures or hospitalization.
2. Because of security concerns, inmates must NOT be informed of follow-up appointments or possible hospitalization.
3. Complete bottom portion of Off-Site Healthcare Referral Form for preliminary documentation of services provided. Return this form in a sealed envelope with the Correctional Officer when inmate is returned to the facility.

NAPHCARE CONTACT: PHONE:

OFF-SITE HEALTHCARE REPORT

Significant Findings/Tests Completed/Diagnosis:

Chalazion LUL

Treatment Provided:

Orders/Recommendations: OK To schedule I+D of lesion OS in Montgomery.

PHYSICIAN: W. Ann Punch DATE/TIME: 12/11/01

NAPHCARE MEDICAL DIRECTOR REVIEW OF CONSULTANT ORDERS/RECOMMENDATIONS

Approved: ___ Revised (see medical record) ___ Signature: [signature] Date/Time 12/12/01

Bill to:
NaphCare
950 22nd St. N.
Birmingham, AL 35203
Phone 1-800-234-2420

Auth# 011203STOPB.

Naphcare7176 Rev. 3/01

(Staton)

NaphCare

OFF-SITE HEALTHCARE/EMERGENCY ROOM REFERRAL

Inmate name: Averette, Zavius. ID#: 217905 SS#:

DOB [redacted] REFERRED BY: Lee D. Bradford, M.D. DATE: 11/12 FACILITY/COST CENTER: 5021

INMATE COMPLAINT/SIGNIFICANT MEDICAL DATA (Chronic conditions, allergies, current medications):

Large Chalazion (L) upper lid.

SERVICES REQUESTED/PROVIDER: Opthalmology - St. Paul. ○ AMBULANCE

10200 Highway 231 North

on 12/11 @ 2:40 pM

MEDICAL DIRECTOR APPROVAL: Lee D. Bradford, M.D. DATE/TIME: 11/12/01

INSTRUCTIONS TO OFF-SITE PROVIDER:

1. Authorization is provided ONLY for requested procedure and treatment of life-threatening conditions. Prior approval of NAPHCARE Medical Director is required for additional procedures or hospitalization.
2. Because of security concerns, inmates must NOT be informed of follow-up appointments or possible hospitalization.
3. Complete bottom portion of Off-Site Healthcare Referral Form for preliminary documentation of services provided. Return this form in a sealed envelope with the Correctional Officer when inmate is returned to the facility.

NAPHCARE CONTACT: PHONE:

OFF-SITE HEALTHCARE REPORT

Significant Findings/Tests Completed/Diagnosis:

Treatment Provided:

Orders/Recommendations:

PHYSICIAN: DATE/TIME:

NAPHCARE MEDICAL DIRECTOR REVIEW OF CONSULTANT ORDERS/RECOMMENDATIONS

Approved: Revised (see medical record) Signature: Date/Time

Bill to:
NaphCare
950 22nd St N.
Birmingham, AL 35203
Phone 1-800-654-2420

Auth# 011203STOPD.

(Staton)

NaphCare

OFF-SITE HEALTHCARE/EMERGENCY ROOM REFERRAL

Inmate name: Averette, Zavius, ID# 217905 SS#

DOB [redacted] REFERRED BY: (EE) for Dr. Bradford/T. Taylor DATE: 11/12/01 FACILITY/COST CENTER: 5021

INMATE COMPLAINT/SIGNIFICANT MEDICAL DATA (Chronic conditions, allergies, current medications):

Large Chalazion (L) upper lid.

SERVICES REQUESTED/PROVIDER:

FAXED 11/13/01 (EE) Opthalmology - Dr. Faulk.

○ AMBULANCE

MEDICAL DIRECTOR APPROVAL: Per Dr. Bradford/EEllis, MD DATE/TIME: 11/12/01

INSTRUCTIONS TO OFF-SITE PROVIDER:

1. Authorization is provided ONLY for requested procedure and treatment of life-threatening conditions. Prior approval of NAPHCARE Medical Director is required for additional procedures or hospitalization.
2. Because of security concerns, inmates must NOT be informed of follow-up appointments or possible hospitalization.
3. Complete bottom portion of Off-Site Healthcare Referral Form for preliminary documentation of services provided. Return this form in a sealed envelope with the Correctional Officer when inmate is returned to the facility.

NAPHCARE CONTACT: PHONE:

OFF-SITE HEALTHCARE REPORT

Significant Findings/Tests Completed/Diagnosis:

Treatment Provided:

Orders/Recommendations:

PHYSICIAN: DATE/TIME:

NAPHCARE MEDICAL DIRECTOR REVIEW OF CONSULTANT ORDERS/RECOMMENDATIONS

Approved: Revised (see medical record) Signature: Date/Time

Bill to:
NaphCare
950 22nd St. N.
Birmingham, AL 35203
Phone 1-800-834-2420

Auth#

EYE EXAMINATION SHEET

TO: (Service Physician)	FROM: (Requesting Ward, Med. Fac. Phys.)	Date of Request:
Bradford	Staton	11/9/01

Reason For Request: (Complaints and Finding)

growth on (L) eye lid (upper) – 3 months

Past History

Old Rx

Ø VA c/o

Signature

Type of Consult ☐ Emergency ☐ Routine

CONSULTATION REPORT

Subjective: OD –~~20~~/~~20~~ S
OS –~~20~~/~~60~~

OPHTH:

New Rx: OD
OS

Seg. Ht.

Ext:
Date Dispensed & Initials:

Seg. Type:

IDP & Time:

LARGE CHALAZIO

Frame:
Size:
Color:

REFER TO OPHTHALMOLOGY
FOR EXCISION

MS 11/9/01
OPTOMETRIST'S SIGNATURE

Patients Last Name	First	Middle	Age	R/S	I D No.
Averette,	Zarius		22		217905

F-65 Rev. (1-95)

LabCorp Laboratory Corporation of America

Laboratory Corporation of America

SPECIMEN	TYPE	PRIMARY LAB	REPORT STATUS	
296-684-3231-0	S	YX	COMPLETE	Page #: 1

ADDITIONAL INFORMATION

SCC

FASTING: Y
DOB: [redacted]

CLINICAL INFORMATION
CD- 41147603818

PATIENT NAME	SEX	AGE(YR./MOS.)	PHYSICIAN ID.	PATIENT ID.
AVERETTE,ZAVIUS	M	25 / 3	WILLIAMS W	217905

PT. ADD.:

ACCOUNT: STATON CORRECTIONAL FACILITY
PRISON HEALTH SERVICES
2690 Marion Spillway Road
Elmore AL 36205-0000
ACCOUNT NUMBER: 01308900

DATE OF SPECIMEN	TIME	DATE RECEIVED	DATE REPORTED	TIME	
10/22/2004	8:00	10/22/2004	10/26/2004	16:39	4049

TEST	RESULT		LIMITS	LAB
Uric A+ANA+RA Qn+CRP+ASO				
Uric Acid, Serum	5.5	mg/dL	2.4 - 8.2	YX
Antistreptolysin O Antibodies	134.0	IU/mL	0.0 - 200.0	YX
C-Reactive Protein, Quant	<0.3	mg/L	0.0 - 4.9	MB
RA Latex Turbid.	11.5	IU/mL	0.0 - 13.9	YX
Antinuclear Antibodies (ANA)	Negative			MB
			Negative <1:80	
			Borderline 1:80	
			Positive >1:80	

LAB: MB LabCorp Birmingham DIRECTOR: Arthur Kelly G MD
1801 First Avenue South, Birmingham, AL 35233-0000

LAB: YX LabCorp Montgomery Hull DIRECTOR: Alton Sturtevant B PhD
543 Hull Street, Montgomery, AL 36104-0000

10/27/04 (W)

Results are Flagged in Accordance with Age Dependent Reference Ranges
Last Page of Report

KILBY CORRECTIONAL FACILI
PO BOX 11
MT. MEIGS, AL 36057

PATIENT NAME
Averette, Carlos

PRISON ID
217905

DATE SUBMITTED
8-16-04

SPC 126

TEST NAME	RESULT	REFERENCE RANGE	COMMENTS
HIV ANTIBODY		NEGATIVE (NEG)	
RPR	NR	NON-REACTIVE (NR)	
URINALYSIS			
APPEARANCE			
pH		pH 5- pH 6	
PROTEIN		NEGATIVE (NEG)	
GLUCOSE		NEGATIVE (NEG)	
KETONES		NEGATIVE (NEG)	
BILIRUBIN		NEGATIVE (NEG)	
BLOOD		< 5 RBC/MCL	
NITRITE		NEGATIVE (NEG)	
UROBILINOGEN		< 1.0 MG/DL	
LEUK. ESTERASE		NEGATIVE (NEG)	
SPECIFIC GRAVITY		1.016-1.022	

8/25/04 (W)

"A" These results are unreliable due to the age of the specimen.
"H" These results are unreliable due to the hemolyzed condition of the specimen.
"A+H" These results are unreliable due to the age and hemolyzed condition of the specimen.

CLIA ID NO. 01D0706289

WAYNE D. MERCER, PHD
LABORATORY DIRECTOR

LABORATORY REPORT

7186923 AREA/ROUTE/STOP: QBHM000
STATON CORRECTIONAL FACILITY
2690 MARION SPILLWAY RD
ELMORE, AL 36025-0056

Quest Diagnostics

MICROFILM# 03010342558

PATIENT NAME	PATIENT ID	ROOM NO	AGE	SEX	PHYSICIAN
AVERETTE, ZAVIUS	217905		23		SONNIER

PAGE	REQUISITION NO	ACCESSION NO	LAB REF #	COLLECTION DATE & TIME	LOG-IN-DATE	REPORT DATE	& TIME
1	2015184	AT980048K		02282003 NG	03012003	03032003	4:37PM

REMARKS

EASTERN TIME

REPORT STATUS	TEST	RESULT IN RANGE	RESULT OUT OF RANGE	UNITS	REFERENCE RANGE	SITE CODE
FINAL						
	Date of Birth: [redacted]					
	A COPY OF THIS REPORT HAS BEEN SENT TO: NAPHCARE INC 950 22ND ST N STE 825 BIRMINGHAM, AL 35203-5300					
	HEPATIC FUNCTION PANEL					AT
	PROTEIN, TOTAL		9.1 H	G/DL	6.0-8.3	
	ALBUMIN	4.2		G/DL	3.7-5.1	
	GLOBULIN		4.9 H	G/DL (CALC)	2.2-4.2	
	ALBUMIN/GLOBULIN RATIO	0.9		(CALC)	0.8-2.0	
	BILIRUBIN, TOTAL	0.8		MG/DL	0.2-1.5	
	BILIRUBIN, DIRECT	0.2		MG/DL	0.0-0.3	
	BILIRUBIN, INDIRECT	0.6		MG/DL (CALC)	0.0-1.5	
	ALKALINE PHOSPHATASE		129 H	U/L	20-125	
	AST	31		U/L	2-50	
	ALT	42		U/L	2-60	
	CBC (INCLUDES DIFF/PLT)					AT
	WHITE BLOOD CELL COUNT	4.7		THOUS/MCL	3.8-10.8	
	RED BLOOD CELL COUNT		5.11 H	MILL/MCL	4.20-5.10	
	HEMOGLOBIN	13.3		G/DL	13.2-15.5	
	HEMATOCRIT	40.7		%	38.5-45.0	
	MCV		79.6 L	FL	80.0-100.0	
	MCH		26.0 L	PG	27.0-33.0	
	MCHC	32.7		G/DL	32.0-36.0	
	RDW	12.1		%	11.0-15.0	
	PLATELET COUNT	156		THOUS/MCL	140-400	
	ABSOLUTE NEUTROPHILS	2980		CELLS/MCL	1500-7800	
	ABSOLUTE LYMPHOCYTES	888		CELLS/MCL	850-3900	
	ABSOLUTE MONOCYTES	658		CELLS/MCL	200-950	
	ABSOLUTE EOSINOPHILS	165		CELLS/MCL	15-500	
	ABSOLUTE BASOPHILS	9		CELLS/MCL	0-200	
	NEUTROPHILS	63.4		%		
	LYMPHOCYTES	18.9		%		
	MONOCYTES	14.0		%		
	EOSINOPHILS	3.5		%		
	BASOPHILS	0.2		%		

>> REPORT CONTINUED ON NEXT PAGE - AVERETTE, ZAVIUS AT980048K <<

INDICATES TESTING SITE SEE REVERSE SIDE

TOP

7186923 AREA/ROUTE/STOP: QBHM000
STATON CORRECTIONAL FACILITY
2690 MARION SPILLWAY RD
ELMORE, AL 36025-0056

LABORATORY REPORT

Quest Diagnostics

PATIENT NAME	PATIENT ID	ROOM NO	AGE	SEX	PHYSICIAN
AVERETTE, ZAVIUS	217905		23	M	SONNIER

PAGE	REQUISITION NO	ACCESSION NO	LAB REF #	COLLECTION DATE & TIME	LOG-IN-DATE	REPORT DATE	& TIME
1	2015097	AT813288K		02212003 7:35 AM	02222003	02222003	4:33A

REMARKS

REPORT STATUS: FINAL

EASTE
TIM

Date of Birth: [redacted]
A COPY OF THIS REPORT HAS BEEN SENT TO: NAPHCARE INC
950 22ND ST N STE 825
BIRMINGHAM, AL 35203-5300

TEST	RESULT IN RANGE	RESULT OUT OF RANGE	UNITS	REFERENCE RANGE	SI CO
COMPREHENSIVE METABOLIC PANEL					
GLUCOSE	99		MG/DL	65-109	AT
			FASTING REFERENCE INTERVAL		
UREA NITROGEN (BUN)	8		MG/DL	7-25	
CREATININE	1.0		MG/DL	0.5-1.4	
BUN/CREATININE RATIO			(CALC)	6-25	
SODIUM	140		MMOL/L	135-146	
POTASSIUM	4.7		MMOL/L	3.5-5.3	
CHLORIDE	102		MMOL/L	98-110	
CARBON DIOXIDE	27		MMOL/L	21-33	
CALCIUM	9.5		MG/DL	8.5-10.4	
PROTEIN, TOTAL	8.3		G/DL	6.0-8.3	
ALBUMIN	3.8		G/DL	3.7-5.1	
GLOBULIN			G/DL (CALC)	2.2-4.2	
ALBUMIN/GLOBULIN RATIO	0.8		(CALC)	0.8-2.0	
BILIRUBIN, TOTAL	0.7	4.5 H	MG/DL	0.2-1.5	
ALKALINE PHOSPHATASE	46		U/L	20-125	
AST	53	148 H	U/L	2-50	
ALT			U/L	2-60	
BC (INCLUDES DIFF/PLT)					
WHITE BLOOD CELL COUNT	4.2		THOUS/MCL	3.8-10.8	AT
RED BLOOD CELL COUNT	4.75		MILL/MCL	4.20-5.80	
HEMOGLOBIN		12.7 L	G/DL	13.2-17.1	
HEMATOCRIT		38.3 L	%	38.5-50.0	
MCV	80.5		FL	80.0-100.0	
MCH		26.8 L	PG	27.0-33.0	
MCHC	33.3		G/DL	32.0-36.0	
RDW	12.2		%	11.0-15.0	
PLATELET COUNT	146		THOUS/MCL	140-400	
ABSOLUTE NEUTROPHILS	2478		CELLS/MCL	1500-7800	
ABSOLUTE LYMPHOCYTES	979		CELLS/MCL	850-3900	
ABSOLUTE MONOCYTES	508		CELLS/MCL	200-950	
ABSOLUTE EOSINOPHILS	223		CELLS/MCL	15-500	
ABSOLUTE BASOPHILS	13		CELLS/MCL	0-200	

Chart MJ 2/24/03

)) REPORT CONTINUED ON NEXT PAGE -- AVERETTE, ZAVIUS AT813288K

SE SID

Kilby Correctional Facility
P.O. Box 11
Mt. Meigs, AL 36057

Averette, Gavins
Patient Name
217905
AIS Number
8/20/01
Date Submitted

NR 32 8/21

TEST NAME	RESULT	REFERENCE RANGE	COMMENTS
HIV 1 & 2 ANTIBODY	✓ NR	NEGATIVE (NEG)	
RPR	✓ NR	NON-REACTIVE (NR)	
URINALYSIS	✓ Neg		
APPEARANCE			
ph		ph5-ph6	
PROTEIN		NEGATIVE (NEG)	
GLUCOSE		NEGATIVE (NEG)	
KETONES		NEGATIVE (NEG)	
BILIRUBIN		NEGATIVE (NEG)	
BLOOD		< 5 RBC/MCL	
NITRITE		NEGATIVE (NEG)	
UROBILINOGEN		<1.0 MG/DL	
LEUK. ESTERASE		NEGATIVE (NEG)	
SPECIFIC GRAVITY		1.016-1.022	

8/21/01
(ad)

WAYNE D. MERCER, PHD
LAB DIRECTOR

LABORATORY REPORT

7186923 AREA/ROUTE/STOP: QBHM000
STATON CORRECTIONAL FACILITY
2690 MARION SPILLWAY RD
ELMORE, AL 36025-0056

Quest Diagnostics

MICROFILM# 03010342558

PATIENT NAME	PATIENT ID	ROOM NO	AGE	SEX	PHYSICIAN
AVERETTE, ZAVIUS	217905		23		SONNIER

PAGE	REQUISITION NO	ACCESSION NO	LAB REF #	COLLECTION DATE & TIME	LOG-IN-DATE	REPORT DATE	& TIME
1	2015184	AT980048K		02282003 NG	03012003	03032003	4:37PM

REMARKS

EASTERN TIME

REPORT STATUS FINAL

Date of Birth: [redacted]
A COPY OF THIS REPORT HAS BEEN SENT TO: NAPHCARE INC
950 22ND ST N STE 825
BIRMINGHAM, AL 35203-5300

TEST	RESULT IN RANGE	RESULT OUT OF RANGE	UNITS	REFERENCE RANGE	SITE CODE
HEPATIC FUNCTION PANEL					AT
PROTEIN, TOTAL		9.1 H	G/DL	6.0-8.3	
ALBUMIN	4.2		G/DL	3.7-5.1	
GLOBULIN		4.9 H	G/DL (CALC)	2.2-4.2	
ALBUMIN/GLOBULIN RATIO	0.9		(CALC)	0.8-2.0	
BILIRUBIN, TOTAL	0.8		MG/DL	0.2-1.5	
BILIRUBIN, DIRECT	0.2		MG/DL	0.0-0.3	
BILIRUBIN, INDIRECT	0.6		MG/DL (CALC)	0.0-1.5	
ALKALINE PHOSPHATASE		129 H	U/L	20-125	
AST	31		U/L	2-50	
ALT	42		U/L	2-60	
CBC (INCLUDES DIFF/PLT)					AT
WHITE BLOOD CELL COUNT	4.7		THOUS/MCL	3.8-10.8	
RED BLOOD CELL COUNT		5.11 H	MILL/MCL	4.20-5.10	
HEMOGLOBIN	13.3		G/DL	13.2-15.5	
HEMATOCRIT	40.7		%	38.5-45.0	
MCV		79.6 L	FL	80.0-100.0	
MCH		26.0 L	PG	27.0-33.0	
MCHC	32.7		G/DL	32.0-36.0	
RDW	12.1		%	11.0-15.0	
PLATELET COUNT	156		THOUS/MCL	140-400	
ABSOLUTE NEUTROPHILS	2980		CELLS/MCL	1500-7800	
ABSOLUTE LYMPHOCYTES	888		CELLS/MCL	850-3900	
ABSOLUTE MONOCYTES	658		CELLS/MCL	200-950	
ABSOLUTE EOSINOPHILS	165		CELLS/MCL	15-500	
ABSOLUTE BASOPHILS	9		CELLS/MCL	0-200	
NEUTROPHILS	63.4		%		
LYMPHOCYTES	18.9		%		
MONOCYTES	14.0		%		
EOSINOPHILS	3.5		%		
BASOPHILS	0.2		%		

>> REPORT CONTINUED ON NEXT PAGE - AVERETTE, ZAVIUS AT980048K <<

INDICATES TESTING SITE SEE REVERSE SIDE

CONTINUED REPORT

LABORATORY REPORT

7186923 AREA/ROUTE/STOP: QBHM000
STATON CORRECTIONAL FACILITY
2690 MARION SPILLWAY RD
ELMORE, AL 36025-0056

Quest Diagnostics

MICROFILM# 03010342558

PATIENT NAME	PATIENT ID	ROOM NO.	AGE	SEX	PHYSICIAN
AVERETTE, ZAVIUS	217905		23		SONNIER

PAGE	REQUISITION NO.	ACCESSION NO.	LAB REF #	COLLECTION DATE & TIME	LOG-IN-DATE	REPORT DATE	& TIME
2	2015184	AT980048K		02282003 NG	03012003	03032003	4:37PM

REMARKS

EASTERN TIME

REPORT STATUS	TEST	RESULT IN RANGE	RESULT OUT OF RANGE	UNITS	REFERENCE RANGE	SITE CODE
FINAL						

Date of Birth: [redacted]

HELICOBACTER PYLORI IGG ANTIBODY		1.99 H	EIA VALUE		AT

< OR = 0.90 NEGATIVE: NO HELICOBACTER PYLORI IGG ANTIBODY DETECTED
0.91 - 1.09 EQUIVOCAL
> OR = 1.10 POSITIVE: HELICOBACTER PYLORI IGG ANTIBODY DETECTED

A POSITVE RESULT INDICATES THAT THE PATIENT HAS ANTIBODY TO H.PYLORI. IT DOES NOT DIFFERENTIATE BETWEEN AN ACTIVE OR PAST INFECTION. THE CLINICAL DIAGNOSIS MUST BE INTERPRETED IN CONJUNCTION WITH THE CLINICAL SIGNS AND SYMPTOMS OF THE PATIENT.

C-REACTIVE PROTEIN		2.51 H	MG/DL	<0.80	AT
LIPASE	33		U/L	7-60	AT

>> END OF REPORT - AVERETTE,ZAVIUS AT980048K <<

INDICATES TESTING SITE SEE REVERSE SIDE

7186923 AREA/ROUTE/STOP: QBHM000
STATON CORRECTIONAL FACILITY
2690 MARION SPILLWAY RD
ELMORE, AL 36025-0056

Quest Diagnostics

PATIENT NAME	PATIENT ID	ROOM NO	AGE	SEX	PHYSICIAN
AVERETTE, ZAVIUS	217905		23	M	SONNIER

PAGE	REQUISITION NO	ACCESSION NO	LAB REF #	COLLECTION DATE & TIME	LOG-IN-DATE	REPORT DATE	& TIME
1	2015097	AT813288K		02212003 7:35 AM	02222003	02222003	4:33AM

REMARKS

EASTERN TIME

REPORT STATUS: FINAL

TEST	RESULT IN RANGE	RESULT OUT OF RANGE	UNITS	REFERENCE RANGE	SITE CODE
Date of Birth: [redacted]					
A COPY OF THIS REPORT HAS BEEN SENT TO: NAPHCARE INC 950 22ND ST N STE 825 BIRMINGHAM, AL 35203-5300					
COMPREHENSIVE METABOLIC PANEL					AT
GLUCOSE	99		MG/DL	65-109 FASTING REFERENCE INTERVAL	
UREA NITROGEN (BUN)	8		MG/DL	7-25	
CREATININE	1.0		MG/DL	0.5-1.4	
BUN/CREATININE RATIO	8		(CALC)	6-25	
SODIUM	140		MMOL/L	135-146	
POTASSIUM	4.7		MMOL/L	3.5-5.3	
CHLORIDE	102		MMOL/L	98-110	
CARBON DIOXIDE	27		MMOL/L	21-33	
CALCIUM	9.5		MG/DL	8.5-10.4	
PROTEIN, TOTAL	8.3		G/DL	6.0-8.3	
ALBUMIN	3.8		G/DL	3.7-5.1	
GLOBULIN		4.5 H	G/DL (CALC)	2.2-4.2	
ALBUMIN/GLOBULIN RATIO	0.8		(CALC)	0.8-2.0	
BILIRUBIN, TOTAL	0.7		MG/DL	0.2-1.5	
ALKALINE PHOSPHATASE		148 H	U/L	20-125	
AST	46		U/L	2-50	
ALT	53		U/L	2-60	
CBC (INCLUDES DIFF/PLT)					AT
WHITE BLOOD CELL COUNT	4.2		THOUS/MCL	3.8-10.8	
RED BLOOD CELL COUNT	4.75		MILL/MCL	4.20-5.80	
HEMOGLOBIN		12.7 L	G/DL	13.2-17.1	
HEMATOCRIT		38.3 L	%	38.5-50.0	
MCV	80.5		FL	80.0-100.0	
MCH		26.8 L	PG	27.0-33.0	
MCHC	33.3		G/DL	32.0-36.0	
RDW	12.2		%	11.0-15.0	
PLATELET COUNT	146		THOUS/MCL	140-400	
ABSOLUTE NEUTROPHILS	2478		CELLS/MCL	1500-7800	
ABSOLUTE LYMPHOCYTES	979		CELLS/MCL	850-3900	
ABSOLUTE MONOCYTES	508		CELLS/MCL	200-950	
ABSOLUTE EOSINOPHILS	223		CELLS/MCL	15-500	
ABSOLUTE BASOPHILS	13		CELLS/MCL	0-200	

Chart MB 2/24/03

)) REPORT CONTINUED ON NEXT PAGE - AVERETTE, ZAVIUS AT813288K ((

INDICATES TESTING SITE SEE REVERSE SIDE

CONTINUED REPORT

LABORATORY REPORT

7186923 AREA/ROUTE/STOP: QBHM000
STATON CORRECTIONAL FACILITY
2690 MARION SPILLWAY RD
ELMORE, AL 36025-0056

Quest Diagnostics

PATIENT NAME	PATIENT ID	ROOM NO	AGE	SEX	PHYSICIAN
AVERETTE, ZAVIUS	217905		23	M	SONNIER

PAGE	REQUISITION NO	ACCESSION NO	LAB REF #	COLLECTION DATE & TIME	LOG-IN-DATE	REPORT DATE	& TIME
2	2015097	AT813288K		02212003 7:35 AM	02222003	02222003	4:33AM

REMARKS

EASTERN TIME

REPORT STATUS	TEST	RESULT IN RANGE	RESULT OUT OF RANGE	UNITS	REFERENCE RANGE	SITE CODE
FINAL						
	Date of Birth: [redacted]					
	CBC (INCLUDES DIFF/PLT) (CONTINUED)					
	NEUTROPHILS	59.0		%		
	LYMPHOCYTES	23.3		%		
	MONOCYTES	12.1		%		
	EOSINOPHILS	5.3		%		
	BASOPHILS	0.3		%		

)) END OF REPORT - AVERETTE,ZAVIUS AT813288K ((

HCX

HEALTH CARE CORRECTIONS

RADIOLOGY SERVICES REQUEST AND REPORT

INSTITUTION STAT2U

Name: Yavius, Averett

State ID No: 217903

DOB: [redacted]

Race: BM Sex:

NOTE PERTINENT CLINICAL INFORMATION AND TENTATIVE DIAGNOSIS MUST BE PROVIDED FOR X-RAY EXAMINATION TO BE PERFORMED

Requesting physician/PA/NP	Date of request	Time of request	Routine	Priority	Transportation or special needs
Lassiter	9-22-04	10:45 am	✓		

HISTORY/DIAGNOSIS: Back/neck + elbow pain

X-RAY REQUEST

	ABDOMEN/KUB		FINGERS		NAVICULAR VIEW		SOFT TISSUE STUDIES
	ACROMIO-CLAVICULAR JOINTS (W/WO WEIGHT)		FOOT		OBLIQUES		STERNUM
	ANKLE		HAND		OS CALCIS(HEEL)		TEMPORO-MANDIBULAR JOINTS
X	CERVICAL SPINE		HIP		PELVIS		THORACIC SPINE
	CHEST PA / LATERAL		HUMERUS		RADIUS/ULNA		TIBIA/FIBULA
	COCCYX		KNEE		RIBS		TOES
	CONE DOWN SELLA TURCICA		LUMBAR SPINE		SACRO-ILIAC JOINTS		WRIST
	[illegible]		[illegible]		SCAPULA		ZYGOMA
	FACIAL BONES		MAXILLA		SHOULDER		ZYGOMATIC ARCH
	FEMUR Yavius		NASAL BONES		SKULL		

REPORT

CERVICAL SPINE: The vertebrae are well aligned and show no evidence of any fracture or any destructive bone disease.
IMPRESSION: NORMAL STUDY.

LEFT ELBOW: The examination shows no evidence of recent fracture or other significant bony abnormality.
IMPRESSION: NO BONY ABNORMALITY IS DETECTED. HOWEVER, IF SYMPTOMS PERSIST A FOLLOW UP EXAMINATION IS RECOMMENDED.

D: & T: 09-30-04 Maurice H. Rowell/jhi Board Certified Radiologist (Signature on file)

DMcCurn 9/30/04

KH, RT
X-RAY TECHNOLOGIST'S NAME(PRINT)

X-RAY TECHNOLOGIST'S SIGNATURE

DATE, TIME EXAM PERFORMED

RADIOLOGIST'S NAME(PRINT)

RADIOLOGIST'S SIGNATURE

DATE SIGNED

*pt stated Lower back is "Fine!" *

D. Nolan, RT

Naphcare

X-Ray Requisition and Report

Name of Hospital/Infirmary	Date of Request	Requested By	Patient Status
SMCU / SCC	2/19/03	B. Helms CRNP	○ Inpatient ● Outpatient

Examination Requested

CXR, PA & Lat, KUB

Clinical Diagnosis

X-Ray Number	Date of X-Ray	Date of PPD Skin Test
	2-21-03	

Report of Findings

AVERETT, ZAVIUS ID#217905

EPA AND LATERAL CHEST: 2-21-03
Normal.

KUB:

Gas and fecal material are scattered in the colon. Gas is seen in a single bowel loop in the left lower abdomen that most likely is small bowel borderline distended. The bowel gas pattern is most consistent with a very mild adynamic ileus. There are a few focal film processing artifacts seen over the upper abdomen but no abnormal mass or calcification seen.

OPINION: MILD ADYNAMIC ILEUS BOWEL GAS PATTERN.

RWF

R. W. FINLEY, M.D./gm

RDTF 2-25-03

File
MD
2/28/03

M.D.
Physician's Signature

Patient's Last Name	First	Middle	Date of Birth	R/S	ID Number
Averette,	Zavius		[redacted]	B/M	217905

X-Ray Requisition and Report

NC059

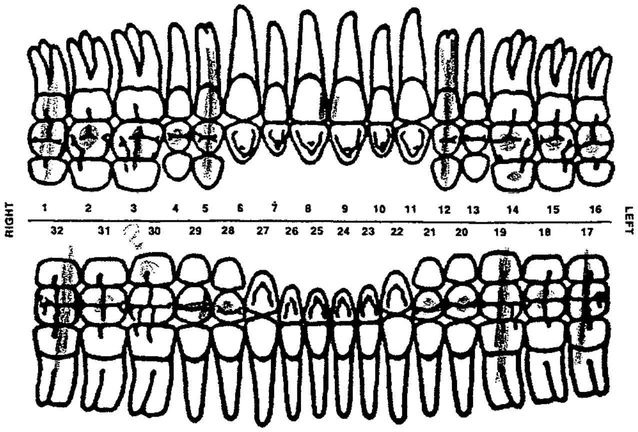
PHS PRISON HEALTH SERVICES INCORPORATED

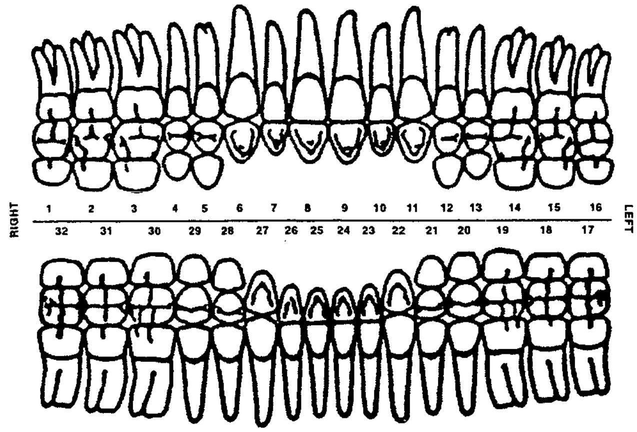
DEPARTMENT OF CORRECTIONS

MENTAL HEALTH SERVICES

DENTAL RECORD

DENTAL EXAMINATION	RESTORATIONS AND TREATMENTS





Date of Initial Examination 12.2.04 annual

Initial Classification

Oral Pathology .... Gingivitis malpositioned cuspids

Vincent's Infection

Stomatitis

Other Findings

Occlusion

Roentgenograms .... Periapical

Bitewing

Other

Health Questionnaire

YES	NO		YES	NO	
☐	☒	Rheumatic Fever	☐	☒	V.D.
☐	☒	Allergy (Novocaine, penicillin, etc.)	☐	☒	Hepatitis
☐	☐	Present Medication muscle relaxer	☐	☒	Anemia or Bleeding Problems
☐	☒	Epilepsy	☐	☒	Heart Disease
☐	☒	Asthma	☐	☒	High Blood Pressure
☐	☒	Diabetes	☐	☒	Kidney Disease
☐	☒	HIV	☐	☒	Other Disease

SERVICES RENDERED

Date	Tooth #	DX	TX	Initials	Class
9/29/05		S/C	Sch for eval #6,11		
			Rx for pain	RB	
12/17/05			Recall due to security	R	

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC.
	217905		B/M	SCC

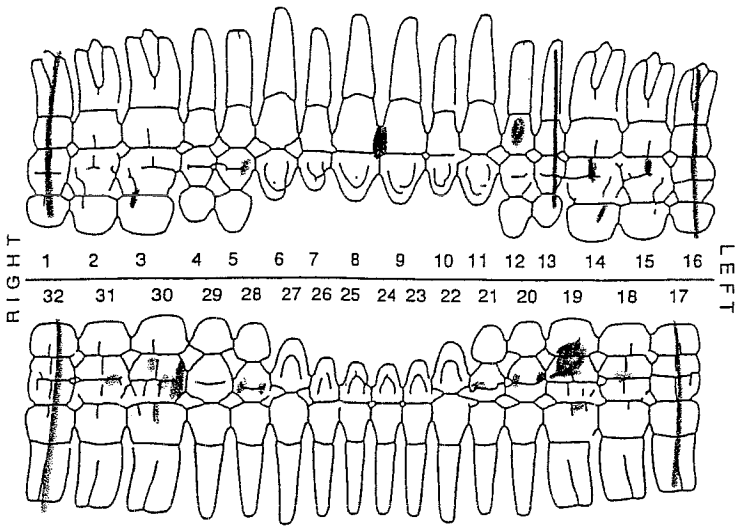
PHS-MD-70015

HaphCare [redacted]

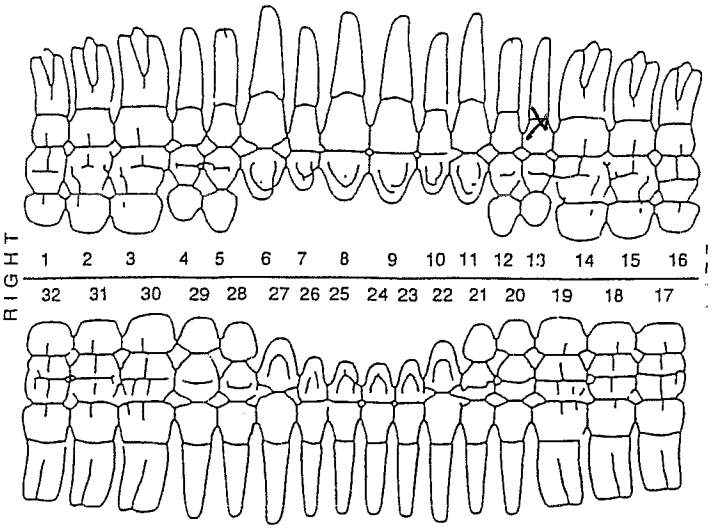
Dental Treatment Record

Name:	ID #:	Race:	DOB:
Arrette, Travis	217905	B	[redacted]

Dental Examination



Restoration and Treatments



Date of Initial Examination:	8-20-01
Initial Classification:	7-18-02
Oral Pathology:	
Gingivitis	
Vincent's Infection	
Stomatis	
Other Findings	
Occlusion	
Roentgenograms:	
Periapical	
Bitewing	
Panarex	

Tooth	Priority List
	7=P
	9=P

Health Questionnaire

Are you in good health?	✓ Yes ○ No	Acquired Immune Deficiency (AIDS/HIV)?	○ Yes ✓ No
Allergies	○ Yes ✓ No	Gastrointestinal disorders	○ Yes ✓ No
Anemia	○ Yes ✓ No	Glaucoma	○ Yes ✓ No
Asthma or other respiratory problems	○ Yes ✓ No	Heart disease or murmur	○ Yes ✓ No
Blood pressure conditions	○ Yes ✓ No	Hepatitis	○ Yes ✓ No
Diabetes	○ Yes ✓ No	Kidney problems	○ Yes ✓ No
Epilepsy	○ Yes ✓ No	Reactions to anesthesia or medications	○ Yes ✓ No
Excessive bleeding after surgery	○ Yes ✓ No	Rheumatic fever	○ Yes ✓ No
Fainting	○ Yes ✓ No	Taking any medication	○ Yes ✓ No
Pregnant?	○ Yes ✓ No	Thyroid conditions	○ Yes ?
Tuberculosis	○ Yes ✓ No	Other conditions	○ Yes

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Zavius Averette Date of Request: 11-30-05
ID # 217905 Date of Birth: _____ Location: 2-79
Nature of problem or request: It been 2months now i still haven't had my dental appointment. They said I'm on schedule. Can you please check it thanks.

Zavius Averette
Signature

DO NOT WRITE BELOW THIS LINE

Date: 12/5/05
Time: 3:00 AM PM
Allergies: _____

RECEIVED
Date: 12/2/05
Time:
Receiving Nurse Intials PP

(S)ubjective: Same as above

(O)bjective (V/S): T: Rest P: _____ R: _____ BP: _____ WT: _____

(A)ssessment: Rest

(P)lan: you have a sch appt in a couple of weeks

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE (X) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

P Patel DA
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

GLF-1002 (1/4)

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Zavious Averette Date of Request: 10-18-05
ID # 212905 Date of Birth: _____ Location: 2-79
Nature of problem or request: I been waiting on my dental ~~appointment~~ appointment for three weeks my name still haven't showed up on the board. my upper gum has got worst.

Zavious Averette
Signature

DO NOT WRITE BELOW THIS LINE

Date: 10/19/05
Time: 1:25 AM (PM)
Allergies: _____

RECEIVED
Date: 10/19/05
Time:
Receiving Nurse Intials PP

(S)ubjective: Same as above

(O)bjective **(V/S):** T: eval P: _____ R: _____ BP: _____ WT: _____

(A)ssessment: eval

(P)lan: you are sch for an appt

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN

CIRCLE ONE
Check One: ROUTINE (X) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

P. Patel DA
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

GLF-1002 (1/4)

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: ZAVIUS AVERETTE Date of Request: 9-19-05
ID # 217905 Date of Birth: _____ Location: 2-79
Nature of problem or request: I got two teeth thats hurting real bad. I want them pulled.

Zavius Averette
Signature

DO NOT WRITE BELOW THIS LINE

Date: 9/29/05
Time: 11:00 (AM) PM
Allergies: _____

RECEIVED
Date: 9/20/05
Time:
Receiving Nurse Intials AP

(S)ubjective: Same above

eval # 6:11

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)ssessment: eval

(P)lan: sch for eval

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE (✓) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

DPatel DA
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

GLF-1002 (1/4)

PRISON HEALTH SERVICES INCORPORATED

PATIENT CONSENT AND AUTHORIZATION FOR DENTAL TREATMENT

Patient Name: Averette, Zanius BCDC#: 217905

1. I agree to having dental X-Rays taken of my teeth and jaws in order to determine my dental problems.

2. I have had a treatment plan explained to me, including alternatives or the recommendation of no treatment.

3. I consent to the use of local anesthetics or other medications and that there may be side effects, including allergic reactions and this has been explained to me.

4. I have had the opportunity to ask questions which have been answered to my satisfaction.

5. I understand there is no guarantee of success or permanence of the treatment.

Patient's Signature

11-04-05
Date

DMD

Dentist's Signature

11-5-04
Date

MaphCare [redacted]

SCC

Health Services Request Form

me Zavius Averelle Date of Request 7-28-02

o. — Date of Birth — Housing Location E-7-25-T

re of problem or request I need to see the dentist about getting two teeth pull

Thanks For your time.

Zavius Averelle

for consent to be treated by health staff for the condition described above.

Place this slip in Medical Box or designated area
DO NOT WRITE BELOW THIS LINE

Health Care Documentation

tive 2/c says upper tooth bothers him if he eats on it - was told he needed to get it out when he had dental screening - cold air + water bother it

e BP____ P____ R____ T____

~~SS~~ make EXT apt.

ent

A Gantt DA 7-29-02